

Addressing the affordability of coverage for high-cost individuals

Recommendation #11 of the Blue Ribbon Commission
on Health Care Costs and Access

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Table of Contents

Background	1
Summary of recommendations	2
Detailed recommendations	4
Broaden funding	4
Improve in chronic care management	7
Change reimbursement rates and plan design	9
Change eligibility and subsidy criteria	14
Next steps	17
Acknowledgements	18
WSHIP revisions work group roster	18

Background

Five percent of the people in our health care system account for 50 percent of the costs. Our challenge is finding an effective way to manage these costs. This challenge is not unique to Washington -- many states have a mechanism for managing the highest cost enrollees in their health care system.

In Washington, we attempt to manage this care through the Washington State Health Insurance Pool (WSHIP). The pool is a public-private partnership that covers anyone with severe and chronic illnesses who has been denied health insurance in the individual market.

Currently, it offers three health plans: a standard indemnity plan with 600 enrollees, a preferred provider plan with 1,700 enrollees, and three Medicare wrap-around plans with 900 Medicare-eligible enrollees. In 2005, more than 6,000 applicants for individual health plans were screened out of the individual market and referred to WSHIP. Only 972, or 1 in 6, actually enrolled. And nearly 800 disenrolled.

Some changes have been made to WSHIP in its 20 year history, but its low enrollment is a clear sign that more reforms are needed if it is to remain an effective tool in managing costs. The Blue Ribbon Commission on Health Care Costs and Access (BRC) addressed investigating this issue in recommendation #11 of its final report.

In this report, the commission charged the Office of the Insurance Commissioner (OIC) with evaluating options for restructuring and improving WSHIP. Four areas in particular have been considered in this report:

- broadening funding
- improving chronic care management
- changing reimbursement rates and plan designs
- changing eligibility and subsidy criteria

In early January, the OIC convened an eight-person work group representing a variety of perspectives from across the health insurance system. The work group met five times through Feb. 22 and developed recommendations for restructuring and improving WSHIP. The following report contains 17 recommendations made by the work group and adopted by Insurance Commissioner Mike Kreidler.

One proposal submitted by the work group could not be adopted in its entirety. The State Constitution prohibits eliminating the guaranteed renewability of WSHIP policies for current enrollees. However, the remaining recommendations provide meaningful reforms and address new methods for increasing enrollment and coverage, improving cost containment, and identifying a broader funding base.

Summary of recommendations

Broaden funding

Recommendation #1: To spread WSHIP's funding base in the short term, the Legislature should appropriate \$5 million in General Fund-state money to the Washington State Health Insurance Pool Account in RCW 48.41.037. If General Fund-state money is added to broaden WSHIP funding in the FY07-09 biennium, premiums should be lowered for low-income enrollees to 100 percent of the average premium in the individual market.

Recommendation #2: The Office of the Insurance Commissioner should convene a task force to recommend the best options for equitable, stable, and broad-based funding sources for WSHIP. The task force should also evaluate the per member, per month threshold used to access the Washington State Health Insurance Pool Account (RCW 48.41.037). The task force will require funding to develop its recommendations. Final recommendations should be made to the Legislature by Dec. 1, 2007.

Improve chronic care management

Recommendation #3: The Legislature should provide the WSHIP board with authority under RCW 48.41.100 to require mandatory participation in care management services and amend RCW 48.41.120 to allow the board to use cost-sharing as an incentive to participate in care management services.

Recommendation #4: WSHIP should continue to coordinate chronic care management services with social service organizations.

Recommendation #5: The WSHIP board should continue to pay supplemental fees to providers who perform care management services.

Recommendation #6: The WSHIP board should continuously evaluate state-of-the art methods to identify enrollees for chronic care management.

Recommendation #7: The WSHIP board should explore the effectiveness of paying for medical advice by e-mail, group visits, or other cost-effective methods of performing quality health care services. It should begin paying for any of these services it finds to be cost-effective by July 1, 2008.

Change reimbursement rates and plan design

Recommendation #8: Amend Chapter 41.05 RCW to make the Uniform Medical Plan (UMP) preferred provider network available to WSHIP plans.

Recommendation #9: Amend WSHIP statutes to provide more benefit design flexibility.

Recommendation #10: Amend RCW 48.41.160 and WSHIP policies to change the current renewal guarantee to a continuity of coverage guarantee for new enrollees. Current WSHIP enrollees should be permitted to maintain their current policies and renewal guarantee.

Recommendation #11: Amend RCW 48.41.020 and RCW 48.41.110 to permit the WSHIP board to offer non-comprehensive plans along with comprehensive plans.

Recommendation #12: Amend the definition of “catastrophic health plan” in RCW 48.43.005 and provide a mechanism for it to increase with inflation.

Change eligibility and subsidy criteria

Recommendation #13: WSHIP should evaluate potential improvements to the Standard Health Questionnaire. In addition, the Legislature should amend RCW 48.43.018 so that former church and federal employees who are exempt from COBRA coverage, and persons leaving the Basic Health Plan with 24 continuous months of coverage at the time of application, are not required to take the Standard Health Questionnaire.

Recommendation #14: The Legislature should amend RCW 48.41.100 to clarify that persons enrolled in Medicaid are not eligible for WSHIP.

Recommendation #15: The Legislature should provide funding for the Office of the Insurance Commissioner to evaluate and recommend adjustments to the 8 percent WSHIP eligibility threshold and the 72 percent individual plan loss ratio in ways that can reduce premiums for individual health plans and WSHIP. This evaluation will require funding and should be completed by Sept. 1, 2008.

Recommendation #16: The Legislature should amend RCW 48.41.200 to provide low-income premium discounts for all ages and to provide the WSHIP board with authority to fund premium discounts from the Washington State Health Insurance Pool Account, if all of the funds appropriated for discounts are expended.

Recommendation #17: The Legislature should amend RCW 48.41.190 to update WSHIP board immunity and extend immunity to WSHIP staff.

Recommendations for improving and restructuring the Washington State Health Insurance Pool (WSHIP)

Broaden funding

WSHIP relies upon enrollee premiums and carrier assessments to fund an annual budget of roughly \$50 million. In order to afford improvements, WSHIP needs to broaden its funding base. Currently, it is primarily funded by assessments paid by health insurance carriers. Employers who self-fund their health care benefits without stop-loss coverage do not pay into WSHIP.

WSHIP provides a social benefit to every Washington resident. But, any efforts to expand coverage or decrease premiums will continue to meet resistance unless we broaden its funding base.

Washington State Health Insurance Pool Source of Funds		
	2005	2006
Premiums	\$17.4 million	\$18.3 million
Assessments	\$36.4 million	\$31.8 million

Source: WSHIP.

Note: WSHIP assessments declined in 2006 because Part D Medicare Drug Benefit coverage replaced a significant portion of WSHIP drug coverage for Medicare-eligible enrollees and the carry forward balance in the pool was larger than in a typical year.

Recommendation #1: In order to spread WSHIP's funding base in the short term the Legislature should appropriate \$5 million in General Fund-state money to the Washington State Health Insurance Pool Account (RCW 48.41.037). If General Fund-state money is added to broaden WSHIP funding in the FY07-09 biennium, premiums should be lowered for low-income enrollees to 100 percent of the average premium in the individual market.

WSHIP faces two main challenges by relying upon enrollee premiums and carrier assessments to fund coverage: a dwindling funding base and the high cost of WSHIP enrollees compared to other state high-risk pools.

WSHIP is funded, in part, by enrollee premiums. The remaining health care expenses are paid by assessments on carriers that provide coverage in Washington's private health insurance market, and those carriers that provide Basic Health and Healthy Options. A carrier's assessment is based on its percentage of covered lives in the market, i.e., larger carriers pay greater assessments. Stop-loss carriers and

the Uniform Medical Plan also pay an assessment, but their share of the losses is based on only 1-in-10 covered lives. Assessments are exempt from a carrier's taxable premium revenue.

Self-funded health plans do not pay an assessment, and often, the largest do not need to purchase stop-loss coverage. Consequently, assessments tend to increase the cost of private health insurance plans relative to self-funded health plans. More private and public purchasers in Washington have chosen to self-fund their health benefits.

From 2002 - 2005, claim payments for self-funded health benefits grew 35 percent in the public sector. In the same time, self-funded claim payments for Washington's two largest domestic health insurance carriers grew 183 percent. As more purchasers self-fund their health care benefits, enrollment in the private health insurance market dwindles and assessments are spread over fewer policyholders.

How do other high-risk pools fund coverage?

Every high-risk pool charges its enrollees a premium. But the similarities end with premium collections. The 33 high-risk pools in other states use multiple financing mechanisms to pay for the inevitable losses between premiums and claim expenses.

Twenty-five pools assess carriers based upon premium or enrollment. Others use a variety of tax exemptions and credits against state premium taxes or general revenues. Seven states assess stop-loss carriers. The newest high-risk pools in Maryland and West Virginia assess hospitals and surgical centers.

Finally, 12 pools receive revenues from general or income taxes, premium taxes, state tobacco taxes, tobacco settlements, or other forms of special funding.

Covering the highest of high-cost enrollees

WSHIP has the highest average claim expenses among high-risk pools. The average cost per enrollee in WSHIP is \$1,418 per month, whereas the average annual cost per enrollee in other pools is about \$631. WSHIP's Standard Health Questionnaire selects only the 8 percent costliest applicants. It's possible that only the highest-risk applicants of those referred to WSHIP actually enroll.

The average premium amount in WSHIP is similar to other high-risk pools. However, WSHIP's premiums cover just one-third of claim expenses. This is the lowest percentage among high-risk pools. Carrier assessments must cover the remaining losses. Washington's average loss per enrollee is the highest among high-risk pools.

The Blue Ribbon Commission on Health Care Costs and Access envisioned a shared responsibility among employers, individuals, and the public sector to finance health insurance coverage. WSHIP is funded by employers indirectly and individuals who purchase private insurance. If not for the recent infusion of federal funds, no general public revenues would finance WSHIP.

Monthly WSHIP Funding and Expenditure Statistics				
	Washington	Average	Median	Notes
Number of Enrollees	3,087	5,699	2,930	Iowa has the lowest (118 enrollees); Minnesota the highest (over 32,000). 14 states have more enrollees than Washington.
Average Premium	\$435	Range: \$115 - \$752	\$421	14 states have a higher average premium than Washington.
Claim Expense (per member per month)	\$1,418	\$631	\$621	Washington has the highest per member, per month claims expense compared to other pools.
Loss Per Enrollee	\$1,076	\$270	\$268	Washington's loss per enrollee is the highest among pools.

Source: WSHIP 2005 annual report.

In 2000, The Washington State Health Insurance Pool Account was created to cover a portion of WSHIP's highest annual expenses. It has yet to be funded. WSHIP's only general revenue funding comes from a \$2.4 million federal award made in 2006.

Funding the Washington State Health Insurance Pool Account would allow other fund sources to act as a kind of reinsurance mechanism. Under RCW 48.41.037, funds from the account can offset carrier assessments when claim expenses reach a per member, per month threshold.

Premiums should be lowered for low-income enrollees only if and when the reductions are associated with the broadening of WSHIP funding.

Recommendation #2: The Office of the Insurance Commissioner should convene a task force to recommend the best options for equitable, stable, and broad-based funding sources for WSHIP. The task force should also evaluate the per member, per month threshold used to access the Washington State Health Insurance Pool Account under RCW 48.41.037. The task force will require funding to develop its recommendations. Final recommendations should be made to the Legislature by Dec. 1, 2007.

The recommendations for non-comprehensive plans, lessening of restrictions on benefits, and lower premiums and more subsidies for low-income enrollees will likely increase carrier assessments. Without a broad funding base, carrier assessments will have to absorb the additional costs.

More time and resources are needed to analyze and confidently recommend a long-term funding mechanism needed for WSHIP. Any choice motivated by expediency, market clout, or supremacy in numbers would not serve WSHIP enrollees or the private health insurance market over the long term.

The Office of the Insurance Commissioner should convene a task force with the charge of recommending to the Legislature by Dec. 1, 2007 the best option for an equitable, stable, and broad-based funding mechanism for WSHIP. The task force should include consumers, purchasers, providers, agents and brokers, and representatives of health insurance carriers and stop-loss carriers. The Legislature should provide the task force with the resources necessary to evaluate these and other options:

- an appropriation of general revenues
- a tax credit or exemption for assessments against collections of general revenues
- a greater percentage contribution from stop-loss carriers and the Uniform Medical Plan
- an assessment on hospitals and surgical centers
- use of other health care resources, funds, or dedicated sources
- other sources of funds or mechanisms that provide stable, long-term, broad-based funding of WSHIP

Improve chronic care management

WSHIP expanded and restructured its chronic care management program in January 2007. It now provides chronic care management services for depression, HIV, asthma, diabetes, coronary artery disease, congestive heart failure, breast cancer, and stem cell/bone marrow transplants.

Recommendation #3: The Legislature should provide the WSHIP board with authority under RCW 48.41.100 to require mandatory participation in care management services and amend RCW 48.41.120 to allow the board to use cost-sharing as an incentive to participate in care management services.

WSHIP's new vendor, Qualis Health, reports that 95 percent of WSHIP enrollees from the prior vendor voluntarily continued with chronic care management services. Of the remaining 5 percent, most reported a stable medical condition or were secure in the self-management of their condition.

WSHIP should follow-up with the enrollees who decline care management services. It might also consider incentives or disincentives to encourage participation in care management. Although incentives or disincentives might encourage universal participation in disease management, the new vendor has advised that requiring participation is unlikely to support the efficient delivery of quality health care services.

The WSHIP board should be granted the authority to require mandatory participation in care management services, to be used if participation declines in the future, or if either adverse quality of care or inappropriate utilization of services is identified among non-participating enrollees.

Based on the recommendations of the new vendor, WSHIP should analyze its new care management services and build upon the practices that efficiently improve the quality of care for its enrollees.

Recommendation #4: WSHIP should continue to coordinate chronic care management services with social service organizations.

Social service organizations often coordinate care for people living with chronic medical conditions. Their services can be instrumental in supporting the continuum of care for a patient.

Depending upon the expertise within the organization, it can sometimes substitute for the non-clinical coordination provided by a care management program. WSHIP should coordinate with social services organizations that complement or even substitute for care management services.

Recommendation #5: The WSHIP board should continue to pay supplemental fees to providers who effectively perform care management services.

WSHIP should identify where its chronic care management program duplicates the effort of clinics that effectively implement quality chronic illness care. It might even choose to provide supplemental payments to clinics that can successfully coordinate care, freeing scarce care management resources for other patients.

Recommendation #6: The WSHIP board should continuously evaluate state-of-the-art methods to identify enrollees for chronic care management.

WSHIP, through its vendor, identifies enrollees for care management services with a combination of hands-on case findings and data mining of health care services data. Predictive modeling is another form of targeting enrollees for care management services. WSHIP should continue to evaluate the potential for using predictive modeling to identify which of its enrollees would benefit from chronic care management services.

Recommendation #7: The WSHIP board should explore the effectiveness of paying for medical services by e-mail, group visits, or other cost-effective methods of performing quality health care services. It should begin paying for any of these services that efficiently deliver quality health care services by July 1, 2008.

The WSHIP board should consider explicitly paying for e-mail, group visits, or other cost-effective methods of providing services that could improve chronic illness care for its enrollees.

Change reimbursement rates and plan designs

Recommendation #8: Amend Chapter 41.05 RCW to make the Uniform Medical Plan (UMP) preferred provider network available to WSHIP plans.

WSHIP contracts for a statewide provider network for its preferred provider plan, and offers lower premiums to enrollees in that plan. The ability to have lower enrollee premiums depends in part on the ability of WSHIP to continue to contract with a comprehensive, cost-effective statewide provider network.

WSHIP annually evaluates the adequacy and cost-effectiveness of its provider network. Few statewide networks are available for comparison, and WSHIP has retained First Choice as its provider network since 1999. WSHIP's low enrollment does not attract other statewide provider networks to compete for its services and does not justify development of its own statewide network.

The Health Care Authority administers the Uniform Medical Plan (UMP) as part of the Public Employees Benefits Board (PEBB) program. The UMP maintains its own comprehensive statewide provider network. Amendments should be made to the UMP statutes to make the UMP network available as an option when WSHIP contracts for a provider network.

Recommendation #9: Amend WSHIP statutes to provide more benefit design flexibility.

More flexibility is needed in the WSHIP benefit plan designs. Benefit limits under RCW 48.41.110(3) should be converted into minimum benefit levels:

- a limit of 180 days of inpatient hospital care per year under RCW 48.41.110(3)(a) would become a minimum benefit of 180 days of inpatient hospital care
- a limit of 30 days of “mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse” care per year under RCW 48.41.110(3)(a) would become a minimum benefit of 30 days per year
- a limit of 100 days per year of skilled nursing services under RCW 48.41.110(3)(e) would become a minimum benefit of 100 days per year
- a defined set of oral surgery services under RCW 48.41.110(3)(m) would be defined as a minimum set of benefits

RCW 48.41.100(2)(a) should be amended so that it no longer sets the lifetime maximum benefit at \$1 million, but instead directs WSHIP to set a lifetime maximum benefit comparable to a majority of Washington individual health plans. Many individual health plans now set the lifetime maximum benefit at \$2 million.

Recommendation #10: Amend RCW 48.41.160 and WSHIP policies to change the current renewal guarantee to a continuity of coverage guarantee for new enrollees. Current WSHIP enrollees should be permitted to maintain their current policies and renewal guarantee.

WSHIP’s policies are guaranteed renewable under RCW 48.41.160, which states:

“A pool policy offered under this chapter shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage.”

Each WSHIP health plan policy currently contains a renewal guarantee similar to the provision in the preferred provider plan (“Plan 3”):

Renewal of Coverage

Subject to the termination provision, your policy will be renewed upon receipt of premium within the 31-day grace period until you are eligible for Medicare.

Termination of Coverage

Your policy will terminate on the earliest of:

- (a) the date premium is due and has not been paid;*
- (b) the date you are no longer a Washington State resident;*
- (c) the date the maximum benefit has been paid by the pool;*
- (d) the date Washington State statutes require cancellation of the policy;*
- (e) the date you become eligible for Medicare;*

- (f) 30 days after the date we [WSHIP] make inquiry concerning your place of residence of eligibility if you do not reply;
- (g) the date that you become eligible for benefits under CHAMPUS.

This means that WSHIP must renew each health plan policy held by an enrollee and may not change any terms of the policy except with the enrollee's consent. However, WSHIP may close a guaranteed renewable plan to new enrollees without offering a replacement plan to the current enrollees.

To meet the twin goals of maintaining continuity of coverage and providing the WSHIP board with the ability to update health plans, a new plan replacement policy should be adopted. The intent of the new policy would be to provide the WSHIP board with more flexibility to design and offer new plans to accommodate the needs of current and future WSHIP enrollees.

Under the new policy, enrollees would be given a guarantee that they could continue their general scope of coverage, but not a guarantee that every specific provision of their current policy would be continued indefinitely.

WSHIP should be required to continue offering comprehensive plans as an option for its enrollees. WSHIP replacement policies would also have to meet requirements similar to those under RCW 48.43.035(4)(b) which deals with the replacement of group health benefit plans in the private health insurance market.

If WSHIP replaces a policy, the replacement policy must be provided to all covered persons within that plan. The replacement policy must include all of the services covered under the replaced policy, and cannot significantly limit access to the kind of services covered under the replaced policy. WSHIP also may allow unrestricted conversion to a fully comparable policy.

The plan replacement policy also should include the requirement that the WSHIP board not replace a policy until it has completed an evaluation of the proposed change's impact upon:

- the cost and quality of care to WSHIP enrollees
- WSHIP financing and enrollment
- WSHIP's ability to offer comprehensive and other plans to its enrollees
- the ability of carriers to offer health plans in the individual market
- other items identified by the WSHIP board

In addition, the WSHIP board also would be required to request input from its stakeholder groups as part of a plan replacement evaluation.

The work group recommends that a continuity of coverage guarantee should replace the current renewal guarantee under RCW 48.41.160 and current WSHIP health plan policies, both for current and future WSHIP enrollees. It also recommends that a two step process described below should be followed.

Step 1: RCW 48.41.160 should be amended to direct the WSHIP board to terminate current WSHIP health plan policies and to replace all but Plan 2 with identical policies that have a continuity of coverage guarantee instead of the renewal guarantee. Each WSHIP health plan contract contains a provision to terminate the policy on the date Washington State statutes require cancellation of the policy. The Legislature should also amend the statute to authorize the WSHIP board to terminate Plan 2 and transfer persons currently enrolled in Plan 2 to the Basic Plus plan.

Step 2: The WSHIP board should implement the new statutory direction described above. The approximately 300 enrollees in WSHIP's Medicare wrap-around plan (Plan 2), would be transferred to Basic Plus. Both Plan 2 and Basic Plus provide prescription drug coverage, but Basic Plus offers it at a lower cost because it wraps around the Part D Medicare Drug Benefit. WSHIP would have to ensure that every Plan 2 enrollee transferring to Basic Plus purchased a prescription drug plan under Part D Medicare Drug Benefit.

The Office of the Insurance Commissioner did not agree with the Work Group recommendations to eliminate the renewal guarantee for current WSHIP enrollees and to transfer all Plan 2 enrollees to the Basic Plus plan. The OIC believes that such changes would involve an "impairment of contract" in conflict with Article I, Section 23 of the State Constitution.

Instead, the OIC recommends that the WSHIP board adopt a new set of plans that replace the renewal guarantee with a continuity of coverage guarantee and that provide the increased benefits listed in recommendation #9. Those plan options should be available to all new WSHIP enrollees. The board should permit and encourage all current WSHIP enrollees to voluntarily transfer to one of the new plans during open enrollment or at other times as may be deemed appropriate by the board.

Recommendation #11: Amend RCW 48.41.020 and RCW 48.41.110 to permit the WSHIP board to offer non-comprehensive plans along with comprehensive plans.

The WSHIP board is challenged to meet both the goal of offering comprehensive benefits and the goal of offering affordable health care coverage. Coverage for mental health, substance abuse treatment, and prescription drugs are among the comprehensive benefits that enable WSHIP enrollees to access the health care services needed to treat their medical conditions.

However, while many high-risk enrollees need comprehensive benefits, two-thirds of those who do not enroll cite the cost of premiums as a barrier. As part of a strategy to enroll more applicants, statutes should be amended to permit the WSHIP board to begin offering non-comprehensive health plans as an option, along with the current comprehensive plans.

Recommendation #12: Amend the definition of “catastrophic health plan” under RCW 48.43.005 and provide a mechanism for it to increase with inflation.

Periods of enrollment in a “catastrophic health plan” cannot be used as a credit against the WSHIP six-month pre-existing condition waiting period in RCW 48.41.110. As more people enroll in qualified high-deductible health plans or opt for higher deductible plans, more WSHIP enrollees will find themselves subject to the pre-existing condition waiting period. In addition, WSHIP applicants with catastrophic coverage cannot receive the premium discount for prior continuous coverage.

RCW 48.43.005(5) defines catastrophic health plan to mean a plan requiring:

- *A deductible of at least \$1500 and out-of-pocket maximum of at least \$3000 for a policy for one enrollee.*
- *A deductible of at least \$3000 and out-of-pocket maximum of at least \$5500 for a policy for more than one enrollee.*
- *Additionally, the definition applies to specific types of health plans that exclude or substantially limit outpatient physician services.*

The deductible and out-of-pocket amounts should be amended as follows:

- a deductible of at least \$1750 and out-of-pocket maximum of at least \$3500 for a policy for one enrollee
- a deductible of at least \$3500 and out-of-pocket maximum of at least \$6000 for a policy for more than one enrollee

They also should be adjusted annually to reflect the Seattle-Tacoma-Bremerton consumer price index for medical care.

Change eligibility and subsidy criteria

Recommendation #13: WSHIP should evaluate potential improvements to the Standard Health questionnaire. In addition, the Legislature should amend RCW 48.43.018 so that all employees who are exempt from COBRA coverage, and persons leaving the Basic Health Plan with 24 continuous months of coverage at the time of application, are not required to take the Standard Health questionnaire.

In 2000, Washington became the only state to use standardized underwriting to refer applicants to a high-risk pool. The goal of standardized underwriting is to provide a fair evaluation of each applicant for an individual health plan and a level playing field for carriers. However, standardized underwriting has proven difficult to implement because it must account for numerous complicated medical conditions across thousands of applicants.

Washington uses the Standard Health questionnaire to standardize underwriting for individual health plans. Currently, it includes 324 medical questions on 35 pages. When an applicant scores over 324 points on the questionnaire, he or she is referred to WSHIP.

The scores for specific medical conditions are available to the public online, and carriers have 30 business days to complete an appeal of an applicant's score. An independent actuary recertifies the questionnaire every 18 months. While the questionnaire helps implement standardized underwriting, it confuses applicants. Carriers also find it cumbersome to administer.

The WSHIP board should retain a consultant to improve the readability and usability of the questionnaire, and evaluate potential improvements to the questionnaire, including:

- integrating the scores for medical conditions into the questionnaire
- reporting online scores following the completion of the questionnaire
- requiring carriers to complete their appeals within 30 calendar days rather than 30 business days

RCW 48.43.018 identifies certain applicants for individual health plans who are not required to take the questionnaire. For example: applicants with 24 months of coverage whose employers have less than 20 employees, and persons who exhaust their COBRA coverage.

However, some persons with employer-provided coverage, such as some church workers and federal employees, are not entitled to COBRA continuation coverage and therefore must take the questionnaire even after they have been covered for more than 24 continuous months.

The following consumers are similar to group consumers with 24 months of coverage and also should not be required to take the questionnaire:

- employees who are exempt from COBRA coverage and have at least 24 months of continuous group coverage at the time they apply for an individual health plan
- consumers who leave the Washington State Basic Health Plan with at least 24 months of continuous coverage at the time they apply for an individual health plan

Recommendation #14: The Legislature should amend RCW 48.41.100 to clarify that persons enrolled in Medicaid are not eligible for WSHIP.

Currently, RCW 48.41.100 specifies that persons whose benefits are “duplicated” under public programs are not eligible for WSHIP coverage. But, due to a lack of clarity regarding legislative intent, WSHIP has not denied coverage to any persons based on RCW 48.41.100(2)(c). As of Jan. 2007, WSHIP covered 37 persons also enrolled in Medicaid.

RCW 48.41.100 should be amended to make it clear that persons enrolled in Medicaid programs under Chapter 74.09 RCW may no longer enroll in WSHIP.

Recommendation #15: The Legislature should provide funding for the Office of the Insurance Commissioner to evaluate and recommend adjustments to the 8 percent WSHIP eligibility threshold and the 72 percent individual plan loss ratio in ways that can reduce premiums for individual health plans and WSHIP. This evaluation will require funding and should be completed by Sept. 1, 2008.

We contemplated making changes to both the 8 percent eligibility threshold for WSHIP and the 72 percent minimum loss ratio applied to carriers’ individual plans. However, due to a lack of time and funding, we could not assess how different eligibility thresholds and minimum loss ratios might impact WSHIP and individual health plan premiums.

The 8 percent eligibility standard was established in 2000 in an effort to bring health insurance carriers back into the individual market. When an applicant is identified as one of the 8 percent persons who would be most costly to treat under individual coverage, the applicant is referred to WSHIP.

Currently about one-in-seven persons referred to WSHIP enroll; two obtain other coverage within a year, and four remain uninsured primarily because they cannot afford WSHIP or premiums in the private health insurance market. This raises the question of whether a different eligibility threshold might lower or stabilize premiums in WSHIP and the individual market.

A carrier pays a remittance to WSHIP when its loss ratio in the individual market is under 72 percent. The potential to pay the remittances gives carriers an incentive to keep premiums and retained income reasonable. Adjusting the loss ratio has the potential to lower premiums in the individual market. Lower premiums in the individual market translate into lower premiums for WSHIP enrollees.

The Legislature should provide funding to the OIC to evaluate the 8 percent eligibility threshold and the 72 percent minimum loss ratio. Any evaluation should consider the impact of changes on the following aspects of WSHIP:

- premiums and enrollment in WSHIP and the individual market, with specific attention paid to those people newly screened in or out of the individual market or WSHIP
- total health care expenses for WSHIP enrollees and the total expenses to those who finance WSHIP
- total health care costs for individual health plan enrollees
- the ability of carriers to offer health plans in the individual market
- the ability of WSHIP to offer comprehensive and other plans

Recommendation #16: The Legislature should amend RCW 48.41.200 to provide low-income premium discounts for all ages and to provide the WSHIP board with authority to fund premium discounts from the Washington State Health Insurance Pool Account, if all of the funds appropriated for discounts are expended.

WSHIP offers a 30 percent discount to enrollees with income below 250 percent of the poverty level and a 15 percent discount when the income falls between 250 percent and 300 percent of the poverty level. But, the premium discounts are only available to 50-64 year-old enrollees.

Four years ago, the Legislature allocated nearly \$300,000 for low-income discounts. WSHIP rarely expends the money and the biennial budget is now roughly \$120,000. In calendar year 2006, fewer than 21 enrollees received a subsidy in a given quarter. In a program where premium costs are the biggest barrier to enrollment, half of the 2005-07 state appropriation for low-income subsidies will not be spent.

Appropriations should continue to be made so that low-income enrollees of all ages receive premium discounts. In addition, to ensure that low-income enrollees will continue to receive premium discounts throughout the biennium, the WSHIP board should be granted the discretion to fund premium discounts from the Washington State Health Insurance Pool Account, if all of the funds appropriated for discounts are expended.

Recommendation #17: The Legislature should amend RCW 48.41.190 to update the WSHIP board immunity and extend immunity to WSHIP staff.

The WSHIP board civil and criminal immunity is outdated and does not extend to the executive director or staff.

The WSHIP board and staff should be provided with the immunity provisions of Substitute House Bill 1507 heard by the 2006 Legislature:

(Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal liability or penalty against the pool, any member of the board of directors, or members of the pool either jointly or separately.)) The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. However, nothing in this section prohibits legal actions against the pool to enforce the pool's statutory or contractual duties and obligations.

Next steps

The effectiveness of our health care system can be observed in how it covers people with HIV, cancer, kidney disease and other severe, chronic, and high-cost illnesses. We cannot successfully reform our health care system unless we find a more efficient way to finance delivery of high-quality health care for people with high-cost illnesses. The recommendations shared in this report provide for significant, immediate, and long-term improvements in the coverage of high-cost individuals covered by WSHIP plans. We urge the Legislature and the WSHIP board to act upon our recommendations.

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